Use for Experience Health Medicare Advantage SM (HMO)

Oxygen
Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

Provider Information		Member Information
Ordering Physician Name:	NPI #:	Member Name:
Office Phone#: Office Fax#:	Contact Name:	Member ID #:
Vendor Name:	NPI #:	Member's Date of Birth:
Vendor Phone #: Vendor Fax #:	Contact Name:	Member's Phone #:
ICD-10 Code(s):		

Please answer questions below

HCPCS code(s) (REQUIRED): _____

Is this an initial oxygen set up, replacement or vendor change?

☐ Initial ☐ Replacement ☐ Vendor Change

If the request is for initial setup:

Date of delivery: _ _ / _ _ / _ _ _ _

Please select one of the following:

1. Did member have a PO2 at or below 55 mm Hg or pulse oximetry at or below 88 percent taken at rest (awake)?
   ☐ Yes ☐ No
2. Did member have a PO2 at or below 55 mm Hg, or pulse oximetry at or below 88 percent, taken during sleep for a member who demonstrates a PO2 at or above 56 mm Hg, or pulse oximetry at or above 89 percent while awake?
   ☐ Yes ☐ No
3. Did member have a decrease in PO2 more than 10 mm Hg, or a decrease in pulse oximetry of more than 5 percent from baseline saturation, for at least 5 minutes taken during sleep associated with symptoms or signs caused by hypoxemia?
   ☐ Yes ☐ No
4. Did member have a PO2 at or below 55 mm Hg or a pulse oximetry at or below 88 percent, taken during exercise for a member who demonstrates a PO2 at or above 56 mm Hg or a pulse oximetry at or above 89 percent during the day while at rest? And was oxygen provided during exercise with documented improvement in hypoxemia?
   ☐ Yes ☐ No

If the request is for replacement or vendor change of current oxygen:

1. Who is the previous oxygen vendor: _____
2. What is the initial setup date of the oxygen: _ _ / _ _ / _ _ _ _
3. Did member request replacement of oxygen equipment? ☐ Yes ☐ No
4. If being replaced before RUL is met; is there a service repair report? ☐ Yes ☐ No

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5.Replacement date of delivery: _ _ / _ _ / _ _ _ _

I certify that I have appropriate authority to request an organization determination for the item(s) indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Experience Health Medicare Advantage SM (HMO) may request medical records for this patient at any time in order to verify this information.

Signature:_____ Date: _____

Please Return Completed Form to:
Fax 1-919-765-7805
For questions please call Care Management at 1-833-941-0107.

Experience Health Medicare Advantage SM is a HMO plan. This plan has a Medicare contract. Enrollment in the plan depends on contract renewal.